| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X1) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | CA040000106 | A. BUILDING: _____ B. WING: _____ | 08/29/2019 |

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| E000 | Initial Comments<br><br>The following reflects the findings of the California Department of Public Health during an investigation of a facility reported incident.<br><br>Facility Reported Incident: 646245<br><br>Representing the Department:<br><br>34510, HFEN<br><br>The inspection was limited to the specific facility reported incident investigated and does not represent the findings of a full inspection of the facility.<br><br>One deficiency was written as a result of facility reported incident 646245. | E000 | | |
| E125 | T22 DIV5 CH1 ART1-70059 Restraint<br><br>Restraint means controlling a patient's physical activity in order to protect the patient or others from injury by seclusion or mechanical devices. This Statute is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to follow its policy and procedure on physical restraint (means of purposely limiting or obstructing the freedom of a person's bodily movement) for one of three sampled patients (Patient 1) when:<br><br>1) Certified Nursing Assistant (CNA) 1 tied Patient 1's legs and knees using a sheet to prevent him from moving without a physician's order.<br><br>2) Registered Nurse (RN) 1 did not monitor Patient 1's physician ordered four point soft | E125 | | |

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| | restraint to ensure safety, proper placement, and correct restraint material.<br><br>These failures resulted in violating Patient 1's rights and potential for injury.<br><br>Findings:<br><br>1) During a review of the clinical record for Patient 1, the Care Management Forms, dated 7/16/19, indicated, "RN [Registered Nurse] reports that this morning at 8:30 AM, she completed a head to toe assessment on patient [1], and noticed a bed sheet wrapped around his knees and upper legs in a knot and it appears to be being used as a restraint."<br><br>During an observation on 7/18/19, at 11 AM, in Patent 1's room, Patient 1 was lying in bed alert with confusion. A bedside mat was on the floor. CNA 2 was sitting outside of his room and was watching Patient 1 constantly.<br><br>During an interview with CNA 2, on 7/18/19, at 11:06 AM, she stated Patient 1 needed constant supervision because Patient 1 tries to get up on his own without asking for assistance and is confused. CNA 2 stated, "He won't listen."<br><br>During an interview with CNA 1, on 7/25/19, at 2:02 PM, she stated Patient 1 kept getting out of the bed, grabbing everything, banging his feet on the wall, keeps getting over the bed, and was already hurting himself. She stated, "So I used a sheet to tie his legs together. I told the sitter about it, she told me to remove it, but I did not remove it." CNA 1 stated she was busy and there were only two CNAs on the floor during the shift. She stated she did not tell the nurse she tied Patient 1's legs. CNA 1 stated, "It's just my discretion, I just went over my role, I was stressed out, we were always short, and I was tired." | | | |

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| | During a review of CNA 3's (sitter) written statement dated 7/22/19, indicated "At 2 AM I checked and released the patient restraints starting from his right hand then his right leg. When I released his leg restraint I realized his leg was moving as if he was still restricted. I assumed since he moved his legs a lot he was tangled under his sheets. I pulled his blanket off and pulled on the sheet from his leg and found that he was tied from his knee with a sheet. Since [CNA 1] was the last person to watch him I confronted her that patient was tied on the knee with a sheet and if she did it. She said she tied the patient [1] with the sheet to prevent him from moving his legs from kicking the bottom rail."<br><br>During a review of RN 2's written statement dated 7/22/19, indicated ". . . At 8:29 [AM] this RN again entered the room to do a complete assessment and administer patient [1's] medications. After listening to his lungs and stomach and assessing his upper anterior [top] skin, I requested for the CNA sitter to come into the room so I could reposition him and assess his posterior lung sounds and skin. Upon entering his room we uncovered his legs and discovered the sheet tied in a knot around his upper calves. We immediately questioned what and why this was done and attempted to untie the large knot. CNA attempted first but was unable to get the knot undone, so then I tried as well. When the knot was unable to be untied, this RN pulled out her bandage scissors and cut the sheet off and placed it in the trash."<br><br>2) During a review of the clinical record for Patient 1, the Physician's Order dated 7/14/19, at 9:54 PM, indicated, "Restraint Type: Soft Limb Left Upper [left arm soft restraint], Soft Limb Right Upper [right arm soft restraint], Soft Limb Left Lower [left leg soft restraint], and Soft | | | |

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| | Limb Right Lower [right leg soft restraint]. Comment: The patient is interfering with care and is in danger of sudden arousal and unpreventable accidental extubation, and/or dislodging of drains, tubes and/or lines, due to disorientation and inability to follow instructions. Alternative measures have been considered and/or attempted and have been found to be unsuccessful in mitigating patient's physical behavior."<br><br>During an interview with RN 1, on 7/25/19, at 4:58 PM, she stated she got the physician's order for four point soft restraint at the beginning of her shift (on 7/15/19, at 10:30 PM). She stated she was not aware CNA 1 tied Patient 1's legs with a top sheet. She stated she did not monitor the four point soft restraint and did not see the tie on Patient 1's legs because his legs were under a sheet. She stated, "I just wish I was more observant."<br><br>During a review of the facility policy and procedure titled "Restraint/Seclusion of Patients" dated 6/28/16, indicated "The facility supports a "restraint free environment" in regards to the use of any mechanical, physical or chemical restraint including behavioral restraint and seclusion. Any form of restraint or seclusion shall be used as a last resort and only within the context where there is risk of imminent danger to patient or others. Staff will work to prevent, reduce and where possible, eliminate the need for use of any form of restraint or seclusion. Staff consistently attempt less restrictive interventions whenever possible to maintain the safety of patients. 4. Violent or Self Destructive Restraint or Seclusion Alone: Patients shall be monitored on an ongoing basis by staff members whoa re stationed nearby the patient. The observations made and data collected during such monitoring shall be documented at least every 15 minutes (Attachment D: Violent/Self Destructive | | | |

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| | Restraint/Seclusion 15 Minute Check Record). 6. Protective Restraints shall be subject to ongoing assessment as specified in the patient's plan of care. Monitoring and assessments shall occur at least every 2 hours and be documented in the patient care recorded every shift. This documentation can be in the form of an end of shift summary or documentation can be in the form of an end of shift summary or documented periodically throughout the shift." | | | |